

The Cloak

The VISN 3 Palliative Care E-Newsletter

Department of Veterans
Affairs

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VISN3 Palliative Care Program: A Year in Review

Submitted by: Therese Cortez NP, ACHPN and Carol Luhrs, MD
Brooklyn Campus - NY Harbor Healthcare System

At the conclusion of FY 2007, our VISN Palliative Care Program continues to strive towards our initiative's mission of honoring veterans' preferences for care at the end of life across all sites and venues of care. We continue to expand our network-based program through ongoing quality improvement, enhancing the expertise of our staff, and collaboration with strategic partners in the community.

We began January 2007, with the implementation of the ongoing VISN 3 Bereaved Family Member Survey for Quality Improvement with inpatient deaths with Palliative Care Consultation. We have trained interviewers, from our interdisciplinary teams throughout the VISN. We are looking forward to this ongoing

quality improvement initiative, as this information will provide us valuable feedback about the end of life care we are providing our veterans and their families during the last few weeks of his/ her life.

In February 2007, each of the sites began the bereavement mailings, which were developed by the VISN Palliative Care Bereavement Taskgroup. These mailings which include bereavement letters, service directory and resources, have been customized and individualized for each of the sites, and mailed to the next of kin of veterans who have died in the inpatient facilities with a PCCT.

Our VISN Palliative Care Quarterly Educational Meetings co-sponsored with EES and the GRECC continue to

provide us an opportunity for enhanced learning and sharing of expertise. Our January 23, 2007 meeting featured Karlynn BrintzenhofeSzoc, PhD, OSW-C, Associate Professor at the Catholic University of America. At our March 27 meeting, we were honored to have Judi Lund Person, MPH, Vice President of Quality at the National Hospice and Palliative Care Organization (NHPCO) speak about Quality in Hospice and Palliative Care. During our June 26, 2007 meeting, ICU champions from each of our facilities joined our Palliative Care team members to hear Dr. Judith Nelson, Intensivist at Mount Sinai Medical Center, speak about Integrating Palliative Care in the ICU.

So Long for Now

Submitted by Mary C. Drayton MSN, PCNP, CHPC. Brooklyn Palliative Care Team

Words always fail you when you most need to rely on them; at least they did me, at the January VISN Quarterly meeting in the Bronx. Now that I have had some time to reflect upon the 4 years spent getting to know and work with most of you I find yet again at a loss for words to truly express what a great honor and a privilege it has been to have been a part of this wonderful palliative care

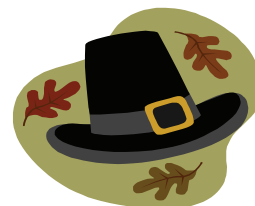
team.

Goodbyes are never easy, even if they stand between you and a promising future. They can be brief or extended over a period of time. They can be a relief or burdensome leaving a void with no immediate fulfillment in sight. Yes, to be sure, they are never easy. So my many friends and colleagues I will not say "goodbye", just so long for our paths will indeed cross

again. How could they not as we continue this important work of educating and caring for those who must exit this world.

Pearls you say, do you have any to leave for us?

"May you all continue to shine forth, illuminating the path ahead so that the road traveled is not as burdensome at the end, as it was in the beginning."



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Calendar of Upcoming Events

- **November** - Face-to-Face PCCT Feedback Meetings: Check for e-mails
- **November 15, 2007** - VISN Noon Case Conference: **Host:** Northport Facility
- **December 13, 2007** - VISN Noon Case Conference: Brooklyn Facility
- **January 22, 2008** - VISN Palliative Care Quarterly Meeting - JJP VAMC - 3D-22 Front
- **February 28 - 29, 2008** - ELNEC, Manhattan Campus Atrium A and B



Stress and the Caregiver Fatigue

By Chaplain Daniel Degyansky, MDiv, BCC, James J Peters VAMC, Bronx, NY

Stress is a natural response of the body to any demand put upon it, and has become an accepted part of our lives in the healthcare profession. Good stress can produce a sense of fulfillment or achievement (e.g. making deadlines or bringing organization out of chaos) or act as an energizer (e.g. participation in, or watching competitive sports).

In contrast, chronic bad stress can result in physical, emotional, psychological and/or spiritual problems in the caregiver. Factors in a healthcare environment that are considered to be bad stress can include such things as secondary trauma or victimization, job stress and caregiver fatigue. The caregiver may feel that he or she is no longer effective in their given vocation. Those to whom we are supposed to provide medical, psychosocial and spiritual care may become de-personalized ("Oh no, not him/her again!"). One might become distanced or resort to avoidance ("I am sorry, but I have *something else* more important to do right now."). One may become detached: withdrawing from basic responsibilities and making oneself scarce, or downright impossible to find. Chronic stress and compassion fatigue becomes and impairment that can lead to depression. One feels dead weary, dead tired, dead exhausted; **JUST DEAD!**

All of us are under stressors that contribute to fatigue,

but the challenge is to prevent them from burning us out. You may be tired at the end of a shift, but say to yourself: "I still do care."

You may feel a sense of loss of energy and the need to revitalize, but this can be remedied with a temporary break, exercise or recreation. You may feel overwhelmed, but able to juggle the busy schedule so patients receive the care they require. You may even feel a bit stiff in the joints at the end of the day, but a good night's sleep can provide the rest needed for the next day. However, if you should feel that you don't care anymore, or your temporary breaks turn into frequent sick days taken, you lose your ideals or hope, feel disengaged and suffer emotional damage from the workplace; perhaps you are in danger of suffering caregiver burnout.

The stressors in our vocation as medical, psycho-social or spiritual caregivers can very seldom be changed in order to make our lives easier. As caregivers we are often "put on a pedestal" (by others and ourselves) and become goal-oriented, trying to please everyone. We are often exposed, almost exclusively, to the negative side of humanity: severe illness, suffering, pain, family systems issues, etc. The weak seek us out, and we respond. We tell ourselves we can rise to any occasion and provide the necessary care. Chaplains repeatedly remind themselves that providing pastoral care is all part of loving one's

neighbor. We find ourselves jumping from crisis to crisis, trying to do too much, finding it impossible to say "no," and in this electronic age (cell phones, pagers, email, etc.) we no longer enjoy privacy. However, even if the stressors seldom change, one can change how stressors are handled in one's life.

The first thing is to take an honest look at oneself and accept the fact that one is simply human and not some sort of "super-hero." One must establish priorities in

"May you never tire in the work that you so diligently do and always look ahead and recognize where you will make a difference."
Mary Drayton

life (on the job and at home) and list them in order of importance. The top three should receive the greatest priority, while the others will be addressed in good time. One should be aware of the continuum of stress in one's life, so as to identify any "red flags" that might pop up and address these stressors in a healthy manner. A clear job description in an environment that requires a variety of job duties is helpful. Frequent short breaks over the course of the day will offer an opportunity to decompress and revitalize. Relaxation techniques such as private prayer, meditation or controlled breathing, can be

used any time of the day. Exercise helps to alleviate pent-up stress and one should work out at least three times a week. It is no coincidence that our sedentary lifestyle is accompanied by stress and the threat of caregiver burnout. Recreation is simply that: *re-creating* one's physical, emotional and spiritual well-being. Seek help and support from colleagues and peers. If one feels that privacy or confidentiality is an issue, one can participate in a variety support groups for social workers, psychologists, chaplains or medical staff apart from one's medical center (e.g. HealthCare Chaplaincy). The areas of life over which one has control requires honesty and courage about one's strengths and limitations, acceptance and discernment.

Avoidance of caregiver fatigue and burnout can be best illustrated by the metaphor of the flight attendant's instructions concerning the oxygen mask (in the event of an emergency). We are instructed to first place a mask *over our own face* before assisting others. If we cannot take care of ourselves, how can we be expected to effectively take care of others?



**WORDS
OF
HEALING**



A Year in Review

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As a result of this meeting, a Palliative Care-ICU Task-group has been developed to strategize and standardize an approach for Palliative Care to be integrated in the ICU in our VISN.

We continue to promote the education of our staff on end-of-life care. On February 28, 2007, our VISN Palliative Care Program, EES, and GRECC partnered with the Lyons PCCT to host an all-day **EPEC** (Education for Professionals in End-of-Life Care) Program at the Lyons VA. A total of 55 attendees from six VA Medical Centers, three State Veteran Nursing Homes and one community home hospice participated in this educational program. Featured speakers included nationally renowned Deborah Grassman, NP, from Bay Pines VAMC, who presented on Wounded Warriors: Caring for Veterans at the End of Life, Prognostication and Spiritual Care. In addition, Diane Jones, MSW, Consultant to the National VA Hospice and Palliative Care Program, spoke about the Hospice Veteran Partnership.

The Bereavement Task-group, in collaboration with VISN Palliative Care Program and EES, also hosted a Bereavement Training Pro-

gram, on July 13, 2007 at the NY VA. Over 100 participants, from VISN 3, community hospice and State Veteran Nursing Homes, attended the all-day Bereavement Training program.

Program speakers included local and nationally renowned experts in grief and bereavement: Ken Doka, PhD; Susan Gerbino, PhD, Allen Levine, LCSW and Richard Hara, PhD. Topics included Spirituality and Bereavement, Uncomplicated and Complicated Grieving, Bereavement in a Group Setting and Utilizing Technology for Bereavement Interventions. We look forward to the continuation of our educational initiatives and the opportunity to collaborate with our community partners and promote the hospice veteran partnership.

Our VISN Palliative Care Strategic Plan for FY 07- 08 has been modified to reflect the newly released NQF (National Quality Forum) Preferred Practices for Palliative and Hospice Care Quality, which is derived from the National Consensus Project (NCP). The elements of the Strategic Plan reflect the core domains of quality palliative care, as defined by the two national initiatives. Each of our VISN Palliative Care Workgroups will continue to review the reformatted VISN Palliative Care Strategic Plan to discuss and implement strategies needed to meet these standards for high quality end of life care.

We met with each of the teams during the feedback meetings in May and June 2007 to review site-specific Bereaved Family Member survey data, Palliative Care Consultation team activities, hospice referrals, compliance with the documentation of the Palliative Care Consult symptom assessment,

psychosocial and spiritual assessments, review of the site Performance Improvement plan, and other identified projects at each site. We are looking forward to this next round of feedback meetings with the teams in November 2007, to promote and support each of the sites' program growth and development.

With many exciting projects ahead of us for the next FY, we would like to take this opportunity to thank each of you

for your commitment to our VISN Palliative Care Program initiatives and goals, and for your compassionate care to our veterans and their families at the end of life.



ELNEC Critical Care: Promoting Palliative Care into the ICU

Submitted by Therese Cortez, NP, ACHPN

In November 2006, seven attendees from VISN 3 participated in the first *ELNEC* (End of Life Nursing Education Consortium) *Critical Care Training Program* in Pasadena, CA. This program is a train-the-trainer program geared to enhance education of the staff in the critical care setting with end of life care. In attendance were Alice Beal, MD (NY Harbor), Therese Cortez, NP (VISN 3), Kathleen Malone, MSN (Brooklyn), Armilita Banzuela, RN (NY), Desiree Lawson, RN (NY), Hanna Hermanowski, NP (NJ) and Janine Decker, RN (NJ).

The ELNEC Critical Care Course included the core components/ modules of the ELNEC-Core Course with content specific to the care of a patient in a critical care setting. Upon completion of the three-day course, the seven attendees proposed to promote the VISN Palliative Care FY 07 Strategic Goal of developing and enhancing Palliative Care-ICU collaborations in their facilities. It is hoped that these collaborations throughout the VISN will strengthen more Palliative Care consultation involvement with the patients with advanced, life-limiting illnesses who are receiving care in the ICU. In addition to the Palliative Care-ICU collaborations, the attendees will be developing an educational curriculum in their respective critical settings which will enhance the knowledge of the front line staff on the needs of patients at the end of life. We look forward to the development of these Palliative Care-ICU initiatives in the next several months, and the continued efforts of our teams to promote the end-of-life needs of our veterans and their families across all settings.



When Caregivers Become Grievors

Submitted by Marianne Tierney, MSW, LCSW, Post Master's Certification in End Of Life and Palliative Care from NYU , Certified Grief Counselor , American Academy of Grief Counseling, Northport VAMC

Informal care giving is a dichotomy. These care givers can be family members and friends who provide care with no pay. They may feel emotionally "strung out", experience anger toward their loved one and feel trapped by the responsibility yet, when given the opportunity for respite, the guilt can be overwhelming. The role is both physically, emotionally and psychologically demanding. The stress of caring for a loved one cannot be overestimated. Providing ADLs can be physically exhausting yet, becomes their reason for living. The care giver is the most ignored person in the caring process.

When a death is expected, it is quite normal for the caregiver to wonder how they will live and cope when their loved one dies. The impending death is accepted cognitively, if not emotionally. They may feel sadness and relief from the responsibility simultaneously. According to a study by the National

Alliance for Care Giving in 2004, most caregivers in our society are women who view this role as their mission in life. They will place their own lives on "the back burner" and withdraw themselves from life.

As time passes, many caregivers change drastically. They experience an array of different types of losses, including the very things that provided happiness and entertainment, in addition to income, control and independence. Grieving for them begins early in the care giving process. Every time a loved one loses the ability to perform a task, the grieving process begins again. Feelings and emotions can be a roller coaster ride. The caregiver may feel happy, sad, hope and desperation all at once.

So what happens emotionally when their "patient" dies? Immediately, the status of the caregiver changes. Not only will they grieve the loss of their loved

one but the caregiver role, as well. According to a survey by Janice Kiecolt-Glaser, PhD of Ohio State University (2001), former caregivers had mild to severe depression two to three years after their spouses' death.

Caregiver grief can be both similar and different than other grief. Although the feelings and emotions can be the same, care giver grief is continuous. The grief begins with a diagnosis and intensifies with each loss that the loved one experiences. Many caregivers grieve for what might have been. Grief after death is the continuation of an extended grieving process. Care giving was exhausting work but grieving is harder. Time feels endless. The caregiver may feel unsure as to where they belong. They no longer provide care, but they aren't ready to give up that role and identity. So much time and energy was invested in caregiving, there was no time for anything else. After

years of providing care, many caregivers find themselves in poor health. Elderly spouses (aged 66-96) who experienced caregiving stress had a higher mortality rate than their non-caregiving counterparts. The focus of care giving has shifted. After years of neglecting themselves, many must learn self care and accept that this is a positive step towards self recovery.

(1) National Alliance for Caregiving and AARP. Caring in the U.S. Bethesda: National Alliance for Caregiving and Washington, D.C.: AARP, 2004. (2) Kiecolt-Glaser, Janice, et al. Former Caregivers Still Show Psychological Ills Years After Caregiving Ends. Journal of Abnormal Psychology (2001; 110:573-584). (3) Schulz, R and .R. Beach, Caregiving as a Risk Factor for Mortality: The Caregiver Health Effects Study, JAMA 282 (1999): 2215-2219.

CNYGEC Comes to Mount Sinai School of Medicine

Submitted by Valerie Menocal, BS, James J. Peters VA Medical Center

The Consortium of New York Geriatric Education Centers (CNYGEC) is a three-year initiative to facilitate the interdisciplinary training of health professional providers, students, and faculty in the diagnosis, treatment, prevention of acute, chronic, and life threatening diseases and disabilities and other health problems of

older people living in New York State.

Led by the Project Director, Judith L. Howe, PhD, Associate Director Education and Evaluation, GRECC. This statewide training initiative, draws on the extensive experience of the Brookdale Department of Geriatrics and Adult Development at Mount Sinai School of Medi-

cine, New York University's College of Nursing, Columbia University's Stroud Center for Quality of Life in Health and Aging and Center for Geriatrics and Gerontology, and the Brookdale Center for Healthy Aging and Longevity of Hunter College. The GRECC is also a CNYGEC partner and will be the home of the project. Deb-

orah Correnti, MS, RN, serves as Project Manager.

The program seeks to expand the number of health professionals trained in geriatrics in urban, suburban and rural areas of New York State, a large and diverse state in many respects. Specialized training in gerontology and

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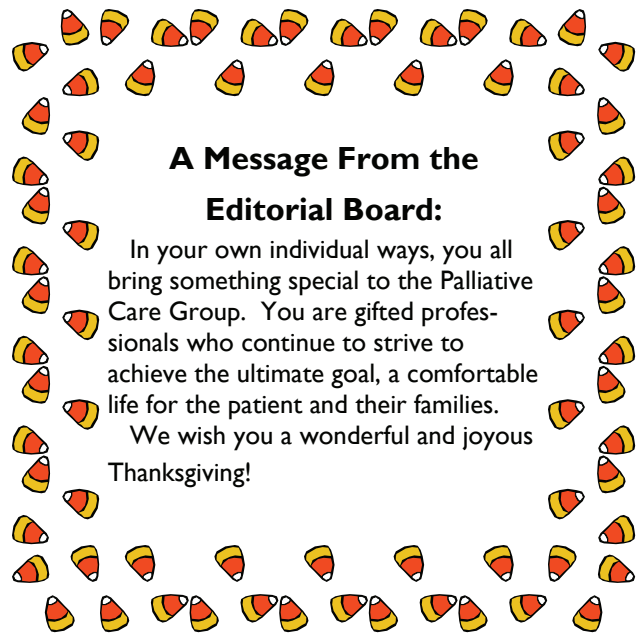
CNYGEC

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geriatrics is essential for health care professionals to meet the healthcare and educational demands of the growing population of elders.

CNYGEC places special emphasis on cultural and linguistically appropriate health care delivery as well as improve health literacy so that information and services are more accessible to older adults. The objectives are based upon the five statutory purposes of the GEC program: (1) improving the training of health professionals in geriatrics; (2) developing and disseminating curricula relating to the treatment of health problems of older people, (3) supporting the training and re-training of faculty to provide geriatrics instructions; (4) supporting continuing education of health professionals who provide geriatric care; and (5) providing students with clinical training in geriatrics in a range of health care settings.

For further information on the CNYGEC contact Deborah Correnti, Project Manager, at 718-584-9000 x 3850 or email Deborah.correnti@mssm.edu.



A Message From the Editorial Board:

In your own individual ways, you all bring something special to the Palliative Care Group. You are gifted professionals who continue to strive to achieve the ultimate goal, a comfortable life for the patient and their families.

We wish you a wonderful and joyous Thanksgiving!

JJP Palliative Care Fellowship New Members

Submitted by Valerie Menocal, BS, Education / Fellowship Coordinator, JJP VAMC

We welcome Mark E. Jones, PhD and Sarah E. Wichman, MSW to the James J. Peters Palliative Care Fellowship Program.

Mark E. Jones, PhD completed his graduate school training at Virginia Polytechnic Institute & State University. For his Psychology internship, Mark worked at the NJ VA Healthcare System with Drs. Sam Spinelli and Larry Weinberger in behavioral medicine and residential substance abuse patients. The title of his dissertation was "Comparing Dispositional and Episodic Assessment of Drug Use Motives among College Students: Prediction of Use and Use-Related Consequences". Mark is thoughtful, considerate and has a knack for listening and responding with insight and comfort. He is poised, confident and has a great sense of humor. Prior to his internship, Mark also obtained clinical and research experience working with interdisciplinary teams and the veteran populations at the VA Medical Center in Salem, Virginia.

Sarah E. Wichman, MSW spent her internship at Metropolitan Jewish Hospice while obtaining her masters degree from New York University School of Social Work. Sarah is genuinely caring and compassionate about the well being of her patients. She is highly motivated to learn and to develop her clinical skills and perform to the best of her abilities. Her presence is very calming and at the same times helps her patients and their families feel safe and taken care of in a mature way. Her goal is "to aid people in seeing palliative and hospice care as an opportunity to help patients spend the end of their lives in as comfortable and fulfilling a way as possible." During her undergraduate years, Sarah volunteered at Duke University Hospital's Pediatric Bone Marrow Transplant Unit.

We are fortunate to have such motivated and dedicated Fellows attuned to the needs of their patients. They are highly recommended individuals with a desire to learn and be a part of this specialized palliative care field.

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